**NORTH CAROLINA DIVISION OF MEDICAL ASSISTANCE**

**PROVIDER CERTIFICATION**

**FOR**

**SIGNATURE ON FILE**

By signature below, I understand and agree that non-electronic Medicaid claims may be submitted without signature and this certification is binding upon me for my actions as a Medicaid provider, my employees, or agents who provide services to Medicaid recipients under my direction or who file claims under my provider name and identification number.

I certify that all claims made for Medicaid payment shall be true, accurate, and complete and that services billed to the Medicaid Program shall be personally furnished by me, my employees, or persons with whom I have contracted to render services, under my personal direction.

I understand that payment of claims will be from federal, state and local tax funds and any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws and I may be fined or imprisoned as provided by law.

I have read and agree to abide by all provisions within the NC Medicaid provider participation agreement and/or on the back of the claim form.

Group or attending provider number to which this certification applies:_____

(Leave blank if submitting with new enrollment packet. A provider number will be assigned once enrollment is complete. This certification is only applicable to the provider number listed above. When the attending number is required on a claim form, each attending provider is required to fill out a separate certification in addition to the group certification.)

_____

Provider Name (must exactly match name on application)

_____

Signature of Provider Listed Above or Authorized Agent Date
(Authorized Agent only applicable for group provider numbers)

Mail completed form to:
(Must be original, faxes not accepted)

DMA-Provider Services
2501 Mail Service Center
Raleigh, NC 27699-2501